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Shared decision making or paternalism in nursing consultations? A qualitative study of primary care asthma nurses' views on sharing decisions with patients regarding inhaler device selection

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Abstract

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Background Although patients with asthma would like more involvement in the decision-making process, and UK government policy concerning chronic conditions supports shared decision making, it is not widely used in practice.

Objective To investigate how nurses approach decision making in relation to inhaler choice and long-term inhaler use within a routine asthma consultation and to better understand the barriers and facilitators to shared decision making in practice.

Setting and participants Semi-structured interviews were conducted with post-registration, qualified nurses who routinely undertook asthma consultations and were registered on a respiratory course. Interviews were recorded, transcribed and analysed using the Framework approach.

Results Twenty participants were interviewed. Despite holding positive views about shared decision making, limited shared decision making was reported. Opportunities for patients to share decisions were only offered in relation to inhaler device, which were based on the nurse's pre-selected recommendations. Giving patients this 'choice' was seen as key to improving adherence.

Discussion There is a discrepancy between nurses' understanding of shared decision making and the depictions of shared decision making presented in the academic literature and NHS policy. In this study, shared decision making was used as a tool to support the nurses' agenda, rather than as a natural expression of equality between the nurse and patient.

Conclusion There is a misalignment between the goals of practice nurses and the rhetoric regarding patient empowerment. Shared

decision making may therefore only be embraced if it improves patient outcomes. This study indicates attitudinal shifts and improvements in knowledge of 'shared decision-making' are needed if policy dictates are to be realised.

Introduction

There is an on-going policy shift within the National Health Service (NHS) in the United Kingdom, from the traditional paternalistic relationship between patients and clinicians to one that emphasizes patient empowerment.^{1,2} This notion is central to the concept of shared decision making, in which patients' values and preferences are considered, and they are involved in the choice of management options.³ The underlying tenet of shared decision making is therefore to increase patients' information, sense of autonomy and control over treatment decisions, thereby decreasing the power asymmetry between health professionals and patients.⁴

Although shared decision making is aspired to in the context of managing long-term conditions, it has proven difficult to implement in practice.⁵ There are several barriers to implementation. These include clinicians' lack of self-efficacy and familiarity with shared decision making,⁶ and a lack of evidence that shared decision making translates into improved patient outcomes.⁷⁻⁹ Time constraints may also be a barrier,⁶ particularly with the introduction of the quality outcome framework (QOF) (<http://www.qof.ic.nhs.uk/>), which provides financial incentives to general practitioners for the performance of key tasks. These barriers need to be overcome: in a sample of mainly primary care patients with asthma, 55% indicated that they would like to be more extensively involved in their treatment decisions.¹⁰ In addition, a recent randomized controlled trial has found that shared decision making significantly improved adherence to asthma pharmacotherapy and clinical outcomes.¹¹

Much of asthma care is provided by primary care nurses,¹² although little is known about their attitudes to and understanding of shared decision making.⁶ The aims of the present study were to investigate primary care asthma nurses' views on

shared decision making and explore how sharing decisions with patients can be facilitated. More specifically, the study addressed the following questions:

1. How do primary care asthma nurses define shared decision making and what is its purpose?
2. What do they perceive to be the barriers and facilitators of shared decision making?
3. Is there a balance of power between nurses and patients when making decisions regarding asthma devices?

Methods

A qualitative approach was adopted (after Ritchie and Lewis¹³) in this exploratory study. Semi-structured interviews were used. These provided an appropriate focus for the interviews, whilst still affording nurses opportunities to add their own perspectives regarding shared decision making.

Study participants

Participants were post-qualification nurses registered on a distance learning respiratory course and attending a study day at a training centre between June 2007 and February 2008. The inclusion criteria were that the nurse currently worked in UK general practice and had undertaken at least three asthma consultations per week during the previous 12 weeks. This ensured that the participants were experienced asthma nurses. However, three less experienced nurses were also included to explore if they held the same views of shared decision making as more experienced nurses. Based on our experience of conducting other qualitative studies, we set a provisional target sample size of 20 participants; there was however provision for the sample size to be increased if topics required further exploration.

One hundred and twelve nurses were sent an invitation letter and were then approached at the beginning of their study day and invited to be interviewed. The first two eligible nurses who volunteered from each of the 11 groups of nurses were selected for interview.

Interview process

Interviews were conducted by JU and HMS, both of whom were appropriately trained prior to conducting field work. Two pilot interviews were conducted, transcribed and discussed with another member of the project team (AC) to ensure consistency of technique between the two interviewers.

An initial topic guide was developed by the multidisciplinary project team (see Data S1) from a review of the literature, prior work, and pooling of relevant clinical (AC, SW, MF and AS), educational and training (SW, MF, HMS and JU), and methodological (AC, JU, HMS and AS) experience and expertise. The topic guide covered the participant's clinical experience, the decision-making process employed by the participant in asthma consultations and perceived barriers and facilitators to shared decision making. Demographic data were also recorded. Interviews lasted between 25 and 45 min. These were audio-recorded and then transcribed verbatim.

As nurses were not recruited from the NHS, this work fell outside the NHS ethics committee's remit. Best practice regarding research governance was followed.¹⁵ All participants provided written informed consent for participation, as well as audio-recording and use of anonymized data extracts. Interviewees were reassured that transcripts would be anonymized and data extracts presented such that it would not be possible for others to identify them from the data.

Data analysis

Transcripts were analysed using the Framework approach.¹⁶ This involved

1. An initial period of familiarization with the data
2. Identifying a thematic framework

3. Indexing i.e. systematically applying the thematic framework to the transcripts
4. Charting i.e. constructing a spreadsheet of indexed quotes and
5. Mapping and interpretation, during which dimensions were identified for all themes for all interviews, and grouped into categories and then higher order categories.

Data were analysed with the support of NVivo software. This was an on-going process conducted by JU and HMS (who are non-clinicians and were therefore relatively uninfluenced by clinical experience or knowledge). This on-going analysis resulted in JU and HMS making minor changes to the topic guide between interviews to ensure that emerging areas of interest were included in the interview. After the analysis of the first nine interviews, JU and HMS found that an initial framework could be inductively created from the data. The project team met to discuss this initial framework. They read the anonymized transcripts and reflexively discussed points of difference. The initial index and emerging themes to be explored in the remaining 11 interviews were agreed, and further changes to the topic guide agreed. These additional topics were as follows: other subjects discussed during the consultations, what the nurse thought was the most important outcome of the consultation, and whether there were any influences from the nurses' personal life that might affect the way they shared decisions with patients.

These first nine participants were sent a synopsis of the emerging themes and invited to comment; none did so. Following completion of all 20 interviews, JU and HMS independently repeated the first three steps of the analysis. The final framework was then discussed, refined and agreed by the project team. The last stage in the analysis involved an inductive process of reflecting on the charted data and searching for non-confirming cases.

After 16 interviews, no new themes had emerged. Following completion of 20 interviews, it was agreed by the project team that further interviews were not required to understand participant's views of shared decision making.

Results

The sample included 20 participants, all female; 12 were studying at diploma level, six at degree and two at Masters level (see Table 1). Their mean age was 43.9 years (range: 34–61 years), with an average of 16.8 years (range: 1–32 years) post-qualification experience. Most participants were experienced at running asthma consultations prior to receiving this training. Three were under the supervision of an asthma nurse, but were experienced primary care nurses who were expanding their skills. Only one participant had prior shared decision-making training. Participants came from across England—predominantly the south-east and south-west.

Nurses' understanding of shared decision making

A summary of the main findings regarding these nurses' understanding of shared decision making and the perceived barriers to and facilitators of shared decision making is listed in Box 1.

Box 1 Main themes emerging from this study

1. Shared decision making was defined by nurses as providing information and offering choice. Interviews revealed that this choice was restricted to a limited number of inhalers.
2. The nurse held the power in consultations.
3. Shared decision making was used as a tool to increase adherence thereby improving patient outcomes.
4. Nurses often made assumptions based on patients' demographic characteristics regarding patients' preferences for type of inhaler and level of shared decision making.
5. Nurses stated that barriers to shared decision making were cost, the QOF and time constraints.

Providing information and offering limited choice

Nurses defined shared decision making as offering patients information and limited choice.

'The hope is that you've given them the information, that they can make that informed choice, and I think that's what shared decision making is.' (P17 Lead asthma nurse, Diploma student)

All the nurses followed a similar type of script when selecting an inhaler. In this script, shared

Table 1 Participant characteristics

Participant Number	Respiratory training being undertaken at time of interview	Years since nurse registration	Experience of running asthma consultations	Shared decision-making training
1	Diploma	12	Under supervision	No
2	BSc	18	Lead	No
3	BSc	13	Missing	No
4	Diploma	26	Lead	No
5	Diploma	20	Lead	No
6	Diploma	12	Lead	No
7	Diploma	14	Lead	No
8	Diploma	11	Lead	No
9	Diploma	3	Lead	No
10	BSc	13	Lead	No
11	BSc	1	Lead	Yes
12	Diploma	29	Under supervision	No
13	Diploma	21	Under supervision	No
14	MSc.	32	Lead	No
15	MSc.	21	Lead	No
16	Diploma	30	Lead	No
17	Diploma	14	Lead	No
18	Diploma	14	Lead	No
19	BSc	16	Lead	No
20	BSc	15	Lead	No

decision making was limited to the provision of information and selection of an inhaler from a limited range of inhalers (see Box 2).

Box 2 Decision-making process

1. A selection of suitable inhalers (i.e. those that could be used to administer the prescribed asthma medication) was chosen by the nurse.
2. This choice was then refined by the nurse, based on her clinical knowledge and information about the patient's lifestyle (which was often assumed).
3. The patient was then invited to choose between the inhalers the nurse had selected.
4. Once the patient had made their choice, the nurse checked the patient's inhaler technique.
5. If the inhaler technique was good, then the nurse agreed with the patient's choice. If not, steps 3 and 4 were repeated until an inhaler was selected that the patient could use properly.

By following this script, nurses may have missed the opportunity to understand the patient's view of inhalers and involve them in the decision-making process.

'I had a lady in a few weeks ago... she brought in reams and reams of information (about a homeopathic inhaler). And you know all I could say was... I didn't know anything about it... and if you want to discuss it further with the GP do so.' (P6 Lead asthma nurse, Diploma student)

'So the patient I've got in mind is in her 60s, never had inhaled steroids but severe asthma, she'd also want to rely on homeopathy even though inhaled steroids had been suggested to her many times, and I convinced, got her to agree to have a trial of inhaled steroids.' (P18 Lead asthma nurse, Diploma student)

Power and persuasion

The selection of a particular asthma inhaler was made through discussion between the patient and the nurse, with the nurse often persuading the patient to agree to their recommendation.

'Sometimes it obviously has to be a compromise, in an idealistic world everybody would listen to what you're saying and do it, it doesn't work like that so you have to compromise to a certain degree and sometimes quite big compromises but mm, if you

get to know someone (and that's the nice thing about general practice is that people come back to you) and you can just slowly chip away and just hope that at some point they may be ready to make that change' (P10 Lead asthma nurse, BSc student)

'Shared decision-making (is when) you would be the informer, to give the patient the choices... and for the patient to decide with you for themselves what their preference would be, and then to come to some agreement somewhere in the middle about what would suit you both. So trying to sort of trying to gently sway them maybe towards what you feel would be the best option, but also listening to their opinion' (P10 Lead asthma nurse, BSc student).

This technique (of using discussion to persuade patients) was also taught to the nurses learning to conduct asthma consultations.

Participant: 'My senior nursing colleague developed) quite a good rapport with the patients, kind of making the patients feel as though they were making the decisions in a round-about way.

Interviewer: Who do you think was actually making those decisions?

Participant: Well I think the nurse was, but of by power of suggestion'. (P12 Nurse under supervision in asthma consultations, diploma student)

Nurses did consider patients to be a partner in the consultation, with the patient's expertise in their condition being acknowledged. However, the partnership was not completely equal: the nurse held the power by virtue of her clinical knowledge.

'That they feel they've had a chance to explain their side of it and really be a part, almost like a partner... They can be the expert in their condition and I think that's got to be shared decision-making.' (P18 Lead asthma nurse, Diploma student)

'... 80–90% of the time it's basically more on my decision. It's going to be isn't it because I'm the one with the power and the inhalers to show them you know, unless they've got some particular knowledge then, it's skewed in my favour.' (P18 Lead asthma nurse, Diploma student)

Sharing decisions to increase adherence

Nurses appreciated the value of sharing decisions as they felt that by giving patients ownership of the decision they were more likely to

use their inhaler, thereby improving patient outcomes. This benefited the patient and the practice:

'... if you don't have shared decision-making, if you inflict an inhaler on a patient that they don't want, they're not going to use it, and if they're not going to use it then their control's not going to be good, so they're going to have symptoms. And when you look at exacerbation rates and those sorts of audit markers it's not good from our side either'. (P15 Lead asthma nurse, MSc. student)

Assumptions made by nurses

Patient preferences for type of inhaler and for level of involvement in decision making were often assumed rather than elicited.

'If it's a child, they love the (brand of inhaler) because they look like spaceships, they're brightly coloured'. (P2 Lead asthma nurse, BSc student)

'It's alright saying "I want this 'touchy-feely' trendy partnership with the patient", but there are some patients, would I be wrong in saying maybe the older patients, I don't want to generalise, who actually want to be told what to do... So you're always making that decision based on the patients communication to you... you don't always get it right, it's a lot of assumptions'. (P18 Lead asthma nurse, Diploma student)

To summarise, nurses viewed shared decision making as a tool to improve patient outcomes through increased adherence. Although the transcripts were explored for divergent views, none of the transcripts contradicted this basic finding.

Barriers and facilitators of shared decision making

Cost, the QOF and time constraints were the main barriers to shared decision making cited by nurses:

'Our primary care trust (PCT) is telling us to take people off combined inhalers... (and) that we are to take them off certain branded inhalers. We've had to overhaul absolutely everybody and put them back on to single inhalers, and to use metered dose inhalers.' (P14 Lead asthma nurse, MSc. student)

The introduction of the QOF was thought by some nurses to result in the nurse 'ticking boxes' on a template rather than spending time focusing on the patient's needs:

'...QOF guide is tick boxes and you sort of lose perception and you lose the focus on patient care I think, sometimes I know I'm doing it, I can feel myself not really taking much notice of the patient' (P1 Nurse under supervision in asthma consultations, diploma student).

Lastly, time constraints were mentioned by nurses:

'If you haven't got time it's easier to say "you're going to have this one" and off they go, it takes longer if you come to a joint agreement because you've got to discuss all the options first and let the person have an input into the final decision' (P5 Lead asthma nurse, Diploma student)

However, it was also suggested by one nurse that time was not a barrier to shared decision making as in general practice patients can be easily invited to attend another appointment. Nurse education, visual aids and patient information booklets were also seen as facilitators of shared decision making as they could help persuade the patient to adhere to their asthma medication.

Discussion

Shared decision making was interpreted and operationalized by nurses as providing patients with information and offering them limited choice. This working definition did not include a 'broad balance in power' between the clinician and patient.¹⁷ Rather, shared decision making was viewed as a skill which experienced nurses employ to give the patient the 'illusion of power'.^{18,19} This was driven by the desire for the patient to have good asthma control, thereby increasing the patient's wellbeing. Although not cited by nurses as a barrier to shared decision making, this objective (of providing patients with a suitable asthma inhaler to obtain good control over symptoms) may be the key barrier to an equal partnership between nurses and their patients. The implicit assumption made by

nurses was that improving the patient's asthma control was more important than sharing power in the consultation.

The script followed by nurses (reported in Box 2) did not alter according to level of experience and reflects current training. This includes teaching nurses about the different types of inhalers, and the importance of ensuring that the patient is able to correctly use their inhaler. It also includes the importance of providing patients with information, which nurses included in their definitions of shared decision making. As previously found with junior doctors,²⁰ information was provided to persuade the patient to conform to the clinician's decision. If patients are to become more involved in decision making, nurses will need to be trained to elicit patients' preferences and concerns, develop a better understanding of what 'shared decision-making' and 'empowerment' mean and become more willing and confident to share decision making more equally with patients.

Strengths and limitations

In this exploratory study, we did not investigate whether views of shared decision making vary between subgroups of nurses, for example nurses recruited directly from general practices or those with less experience. Future studies should use purposive sampling to explore whether views of shared decision making vary between these subgroups of nurses.

Participants were attending a variety of post-qualification training, which have study days at different times. It is therefore not possible to comment on the impact of the training on views of shared decision making. However, none of the respiratory courses attended by these participants, including the distance learning course from which the interview sample was drawn, include training in shared decision making. Rather, they emphasize the clinical skills and knowledge needed to conduct consultations with people with chronic respiratory diseases.

The decision to select the first two volunteers may have biased the sample towards more assertive personalities, which may have influenced

responses. Less forthcoming nurses may have responded differently, although there is no way of ascertaining this with any degree of certainty. The sample did include three nurses who were under supervision. These three nurses had conducted numerous asthma consultations under supervision and could therefore comment on the decision-making process. Their views did not diverge from those expressed by participants who were more experienced asthma nurses; these nurses seem to have adopted the views of their supervisors.

Implications for policy, practice and research

In contrast to the NHS drive towards patient empowerment, nurses in this study appeared to maintain a paternalistic attitude to patients. This may be because many nurses have to meet targets outlined by the Quality Outcomes Framework, within the time constraints of the consultations. However, nurses in general practice have the opportunity to share decisions with patients over a number of consultations. Time constraints cannot fully explain why shared decision making does not occur in this context.

Rather, we propose that there is a fundamental misalignment between the goals of practice nurses and the rhetoric regarding patient empowerment. This has resulted in the tool of shared decision making being adapted by nurses to meet their own agendas. Shared decision making is likely to continue to be used in the manner described here unless there is a shift in nurses' perception of shared decision making whereby more priority is given to sharing power between patient and nurse. This would require a fundamental shift in the culture of the health professional/patient consultation within the NHS.

Conclusions

The primary care nurses included in this study all agreed in principle that decisions should be shared with their patients. The extent of shared decision making was restricted, though, by nurses' understanding of the philosophy of shared decision making and by the nurses' responsibility to improve patient outcomes by ensuring patients were provided with suitable

inhalers. This study indicates that government policy papers (for example, High Quality Care for All¹) alone are unlikely to be sufficient for power to be shared equally with patients. Shared decision making is only likely to be fully embraced if clinicians perceive the benefit of sharing decisions, or if there is evidence that it will help clinicians to meet their own targets and objectives. However, there are relatively few studies, particularly in asthma, which provide rigorously tested shared decision making models/interventions that could be adopted; recent work by Wilson *et al.*¹¹ is a promising development, but further work in this area is needed. This study indicates attitudinal shifts, and improvements in knowledge and understanding of 'shared decision making', are needed if policy dictates and ambitions are to be realised.

Conflicts of interest

This study was funded by the pharmaceutical company AstraZeneca via an unrestricted research grant. AstraZeneca had no input into the study design, data collection, analysis or interpretation of the findings. MF and SW have received travel bursaries and consultancy payment from AstraZeneca as well as other manufacturers of other asthma medications including GlaxoSmithKline, Trinity Chiesi, Merck, Sharp and Dohme and Boehringer Ingelheim.

Supporting Information

Additional Supporting Information may be found in the online version of this article:

Data S1. Topic guide.

Please note: Wiley-Blackwell are not responsible for the content or functionality of any supporting materials supplied by the authors. Any queries (other than missing material) should be directed to the corresponding author for the article.

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